Indiana Access To Recovery (ATR) – Client Choice Form

INATR – 001 – Marion

I _____, IDOC#_____understand that the Indiana Access to
(Enter Client's Name) (If applicable)
Recovery is a voluntary program and that my participation in the program is because I want to recover from my addictions. I understand that there are a number of providers qualified to provide any service that I may require during my participation in the ATR program. I also understand that I may choose the providers that provide services to me while I participate in the program. I understand that the following providers are ready to provide Indiana ATR clients with recovery consultation.

Name of Organization	**Phone**	**Fax**
ANSAR	317-291-4444	317-713-1141
Community Outreach Network Services	317-524-6841	317-524-6844
Rich Recovery Services	317-926-5822	317-926-0604
Women Entrepreneurs of America – Project Return	317-890-0933	317-890-0904
MSD of Wayne Township – Adult Education Program	317-248-8616	317-243-5537
PACE/OAR	317-612-6800	317-612-6811
Volunteers of America	317-234-1931 Ext. 238 or 317- 432-4080	317-234-1939
Workforce, Inc.	317-532-1367	317-532-1369
Julian Center (female clients only)	317-941-2200	317-937-7093
The Way to Recovery	317-946-2844 (female clients) or 317-985-5907 (male clients)	317-328-3437(f) 765-483-9844 (m)

From the above list I have selected _____ (Enter Name of Recovery Consultant Organization) to provide this service. No one has exerted pressure on me to select this particular provider and I am confident that this provider is best suited to meet my needs for recovery consultation. I understand that if I find that this provider does not meet my needs, I may select another provider to replace this provider at any time. I understand that _____ (Enter Name of Recovery Consultant Organization) may not be willing or have the ability to provide recovery consultation to me, in which case I will need to select a different provider.

I understand that the Recovery Consultant will need to contact me. I authorize my chosen Recovery Consultant to contact me by contacting me at the following:

Address: _____

Home Phone: _____ Cell Phone: _____Work Phone: _____

I authorize the referral agency to release my information to help the Recovery Consultant contact me:
Referral Agent: _____Phone:_____

Referral Agency: _____

_____ _____/_____/_____
Signature Date

If this is an IDOC referral, please fax a copy of this referral to Amanda Copeland @ 317-233-1474